



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Benson Chee, MD

Respondent Name

Hartford Insurance Company of Midwest

MFDR Tracking Number

M4-15-2469-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

April 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services were requested and prescribed by the Division...

New Rule §134.204(i) describes all six examinations performed by designated doctors, but directs the reimbursement for MMI/IR examinations performed by designated doctors to subsection (j), and excludes reimbursement for MMI/IR from the tiered reimbursement structure of subsection (i) for multiple examinations performed by the designated doctor. MMI/IR examinations performed by designated doctors do not result in the tiering of the non-MMI/IR examinations.

When conducting exams for issues other than MMI/IR, apply the new tiered reimbursement method described in rule 134.204 (i) to the remaining four exams. **Reimbursement for one of these exams is \$500.** When conducting more than one of these exams under the same request, the first exam is reimbursed at 100% of the fee for the exam, \$500; the second exam is reimbursed at 50% of the fee for the exam, \$250; and the subsequent exam(s) are reimbursed at 25% of the fee for the examination, \$125...

We seek full reimbursement for the outstanding balance of \$500.00 along with interest accrued according to Rule 134.803 Calculating Interest for Late Payments on Medical Bills."

Amount in Dispute: \$500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As the attached explanations of benefits describe, reimbursement was paid pursuant to the applicable fee guidelines. [The requestor] has failed to adequately explain why he is entitled to the additional reimbursement requested."

Response submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2014	Designated Doctor Examination (RTW)	\$500.00	\$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
For CPT Code 99456-W8-RE:
 - 943 – Documentation does not support billed charge. No recommendation of payment can be made.
 - 275 – The charge was disallowed; as the submitted report does not substantiate the service being billed.
 - 16 – Claim/service lacks information which is needed for adjudication.
 - B12 – Services not documented in Patients' medical records.
 - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not "reasonable or necessary". The amount adjusted is generally not the patient's responsibility, unless the workers' compensation state law allows the patient to be billed.
 - 247 – A payment or denial has already been recommended for this service.
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - 947 – Upheld No additional allowance has been recommended.
 - OA – The amount adjusted is due to bundling or unbundling of services.

Issues

1. Was the insurance carrier's denial for payment of disputed CPT Code 99456-W8-RE supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "943 – Documentation does not support billed charge. No recommendation of payment can be made," "275 – The charge was disallowed; as the submitted report does not substantiate the service being billed," and "B12 – Services not documented in Patients' medical records." Review of the submitted documentation finds that the insurance carrier requested an evaluation of the injured employee's ability to return to work by the designated doctor for unspecified dates. The narrative indicates that the designated doctor addressed this question on page 3 and provided the required Division report (DWC-73: Work Status Report). Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. While CPT Codes 99456-W5-26, 99456-W5-TC, and 99080-73 were included on the Request for Medical Fee Dispute Resolution (DWC060), the paid amounts are not in dispute. Therefore, these codes will not be considered in this decision.

Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine Return to Work. Therefore, the correct MAR for this examination is \$500.00.

3. The total allowable for the disputed CPT Code 99456-W8-RE is \$500.00. The insurance carrier paid \$0.00. Therefore, an additional reimbursement of \$500.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Laurie Garnes	May 28, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.